STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165190	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan - Algona	412 West Kennedy Street Algona, IA 50511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record, facility policy, resident and staff interview, the facility failed to provide a restorative exercise program for 1 of 3 resident reviewed (Resident #24). The facility reported a census of 61 residents. Findings include: Resident #24's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS revealed the resident had diagnoses of Parkinson's Disease, pain in unspecified knee, and muscle weakness. The current Care Plan updated 5/22/25 directed the staff to provide passive range of motion (PROM) hand strengthening blue digi-flex, resistance 25 reps bilaterally for 2 sets 3-6 times per week, Active range of motion (AROM) to upper extremities for 8 minutes overhead pulleys against resistance no weights 3 times per week, and lower extremities supine exercises: ankle pumps, heel slides, (assisted), hip abduction, (assisted), Short Arc Quad (SAQ) exercises, Straight Leg Raises (SLR), quad sets to bilateral sides of body, 3-5 times a week. Further review showed the Care Plan identified Resident #24 at risk for pressure ulcer development related to limited mobility. Resident #24's restorative charting lacked documentation of the program being completed as ordered by therapy for the past 3 months. Resident #24's Progress Notes lacked documentation of refusal to complete the restorative program for the past 3 months. On 12/02/2025 at 4:00 PM the Administrator reported there is no documentation of restorative being offered or completed for Resident #24. He reported he expects the restorative programs for the residents to be completed. On 12/03/2025 at 10:55 AM Resident #24 reported staff do not offer restorative exercises but if they did, he would do them. The facility policy titled Rehab/Skilled and Long Term Care: Therapy and Rehab with a revised date of 7/7/25 directs staff how to document the restorative nursing but lacked direction to ensure completing the program.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide adequate supervision to prevent elopement with a fall for 1 of 3 residents reviewed (Resident #67). The facility reported a census of 60 residents.Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #67 scored12 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident required substantial/maximal assistance with transfers and ambulation. The resident's diagnoses included stroke, non-Alzheimer's dementia, and disorientation.The Care Plan dated 10/14/22 identified Resident #67 had impaired cognitive function related to dementia and stroke. The resident thought people were stealing her snacks which she ate and offered other residents. The resident had a history of going in to other resident's rooms and rummaging through their belongings. Interventions included monitoring/documenting/reporting to the health care provider any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, or mental status. They posted the resident's name on her room door in the hallway with a yellow bow. When the resident was at home she was not sleeping at night, and thought people were coming into her home and stealing from her. The Care Plan dated 5/27/22 identified the resident had impaired visual function related to cataract. The interventions included the resident would maintain a safe environment due to vision loss. The Care Plan dated 5/27/22 identified the resident at high risk for falls related to vertigo and stroke like symptoms. The interventions included ensuring/providing a safe environment.The Progress Notes 8/7/25 at 10:37 a.m. documented when staff went to get resident for an activity, she had ripped her calendar off the door, her water pitcher upside down on her side table and her tv hanging by the cord about hitting the floor. She stated that she needed to get her stuff packed up because she heard on the overhead page that everyone needed to pack their stuff up to leave.The Progress Notes dated 9/19/25 at 11:35 a.m. documented during bus ride, the resident reached for things in the air and off the ground that were not there.The Progress Notes dated 9/20/25 at 11:36 a.m. documented staff went into Resident #67's room to get her for an activity. The resident had a white cream all over her face, hands, clothes, and beside table. A Certified Nursing Assistant (CNA) went in and cleaned her up. When staff went back in to get her, she tried drinking her pop that was not yet open.The Elopement Risk dated 10/9/25 indicated Resident #67 had not exhibited or experienced increased confusion and forgetfulness, and had not exhibited packing of belongings or verbalizing statements about leaving.The Progress Notes dated 10/20/25 at 6:50 p.m. documented the nurse summoned by another resident for help outside. Upon arrival Resident #67 found face down, off the curb at the front entrance of the facility. A CNA returning from break, present at resident's side. The resident had a small amount of bleeding from her left upper forehead, and under her right eye. The resident complained of left knee pain. The resident had a (high) blood pressure (BP) of 215/124. At 7 p.m. placed a call to the hospital. The on-call physician informed of the event, current blood pressure, and resident complaints of knee pain. Received the order to transport the resident to the Emergency Department.On 12/3/25 at 2:11 p.m. Staff A Registered Nurse (RN) stated she was on the eve that Resident #67 fell. She said another resident reported she had fallen outside. She did not know how she got out, if someone let her out or if she got out herself. Staff interviews about resident prior to falling outside: On 12/4/25 at 8:53 a.m. Staff B CNA stated Resident #67 always wanted to go home, and would talk to her son or some other distraction. She didn't normally go to the doors but if she did and it was nice outside, they would go out with her. Staff B stated Resident #67 was an elopement risk.On 12/4/25 at 8:57 a.m. Staff C Licensed Practical Nurse (LPN) stated the resident did talk about going home but not aware of attempt to elope. She said anyone without a wander guard (bracelet worn to alert if a resident attempting to go out) could go out the front door and there was no (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alarm. She said the resident had been failing.On 12/4/25 at 9 a.m. Staff D CNA stated the resident wanted to call her family member, a lot. She could not recall her trying to go out of the facility.On 12/4/25 at 9:05 a.m. Staff E CNA stated the resident would say she wanted to go home once in awhile. She didn't see her try to leave. She said the resident had been declining, needing more assistance with eating, transfers and walking. She hadn't been asking to call her son as much.On 12/4/25 at 9:08 a.m. Staff F CNA stated Resident #67 talked about going home and she knew she had gone through the 1st door but staff stopped her before she went through the 2nd door, to the outside. On 12/4/25 at 9:15 a.m. Staff H CNA stated Resident #67 did talk about leaving.On 12/4/25 at 9:43 a.m. Staff J CNA stated Resident #67 would say she needed to get out of here. On 12/4/25 at 10 a.m. Staff K CNA stated she worked the night Resident #67 got outside. She did not see when it happened. She just heard a staff member came back from break and heard her yelling. Prior to the incident the resident had been more confused. She had not witnessed her trying to leave, but she talked about it.On 12/4/25 at 10:08 a.m. Staff L CNA stated Resident #67 would say she wanted to go home. She had a hard time getting around.On 12/4/25 at 3:35 p.m. Staff M CNA stated she worked the shift when Resident #67 got outside. She had gone to break. When she came back she parked in the back lot, and could hear someone screaming. She went to the front lot and she saw the resident face down on the ground. She had rolled off the curb.On 12/4/25 at 8:14 a.m. the Administrator stated the front door had a wander guard, otherwise no other alarm sounded during the day. The door alarm automatically engaged at 10 p.m. and disengaged at 6 a.m. Between 10 and 6 a person would have to put the code in or the alarm would sound.The facility Elopement policy dated 4/7/25 defined elopement as a resident who needed supervision left the premises or safe areas without authorization and or necessary supervision to do so. When an elopement occurred they would notify other agencies as required by state and/or federal regulation.